

Application for Disability Accommodation
Pharmacy Licensing Examinations

PART I: APPLICANT'S STATEMENT

Name: _____

Address _____

Social Security Number: _____

Telephone Number: _____

Birth date: _____

Examination: NAPLEX _____ MPJE _____

Description of disability and how it impacts taking examinations: _____

Physician, Therapist, or Other Health Care Practitioner: (List additional practitioners on a separate sheet of paper and attach to this form.)

Name: _____

Office Address: _____

Telephone Number: _____

Length of Time as Patient: _____

Type of Accommodation(s) Requested: _____

If you have previously been provided with test accommodations(s), please list the provide and describe the accommodation(s): _____

RELEASE

I authorize the practitioner(s) listed above to release to the Tennessee Board of Pharmacy (The Board) or its legal representative any and all information in his or her possession about my disability described above. "Information" means all information in the possession of, or derived from, providers of health care regarding my medical history, medical condition, or treatment. I agree that this authorization shall be valid until canceled in writing by me. I understand that the Board of Pharmacy will use the information obtained by this authorization to determine eligibility for a reasonable accommodation with regard to the pharmacist licensure examination by reason of my disability. The Board reserves the right to require additional information or documentation to support this request for accommodation. The Board will not release any information obtained to any person or organization, except to NABP® (the test developer), or any government agency that may be involved with my application to take the pharmacist licensure examination. Under penalties of perjury, I declare that the foregoing statements and those in any accompanying documents or statement are true. I understand that false information may be cause for denial or loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature: _____ Date _____

Subscribed and sworn to before me this _____ day _____ 20_____

Notary Public: _____